WILBERT FUNERAL SERVICES, INC.
Group # H870825
Effective January 1, 2018
Cost Plus HSA Plan

PLEASE CONTACT GROUP & PENSION ADMINISTRATORS OR THE PPO NETWORK AT THE PHONE NUMBER OR WEBSITE SHOWN ON YOUR PLAN I.D. CARD FOR INFORMATION ABOUT WHICH PROVIDERS ARE INCLUDED.

Deductible and Annual Out-of-Pocket Maximum	Facility and PPO Physicians	Non-PPO Physicians
Calendar Year Deductible • Per Covered Person • Family Limit*	 $2,700 $5,400	 $2,700 $5,400
Annual Out-of Pocket Maximum (Includes Deductible) • Per Covered Person • Family Limit*	 $2,700 $5,400	 $5,400 $10,800
* Applies collectively to all Covered Persons in the same Family.		

LEVEL I FACILITY BENEFITS – Payment Levels:
This section applies to covered expenses for services rendered by Hospitals and other types of facilities which are not included in the **Preferred Provider Organization (PPO) network**.

Benefit Percentage For:	Facility Benefit *	Maximum Benefits, Limits & Provisions
Inpatient Hospital Services	100%; Deductible applies	**Failure to receive prior authorization thru HealthWatch (UR Company) results in a benefit of 80%.
Maternity Inpatient Hospital Services	100%; Deductible applies	Contact UR Company for coordination of care.
Routine Newborn Care Inpatient Hospital Services	100%; Deductible waived	Payable under covered mother's claim.
Rehabilitation Facility	100%; Deductible applies	**UR Notification required or reduced benefit applies.
Skilled Nursing Facility	100%; Deductible applies	**UR Notification required or reduced benefit applies. Limited to 30 days per Calendar Year.
Hospital Services for Mental/ Nervous Disorders, Chemical Dependency, Drug and Substance Abuse Inpatient**/**Residential Treatment Facilities Outpatient/Day Treatment Facility	 100%; Deductible applies	**UR Notification required or reduced benefit applies.
Hospital Emergency Room (all related charges)	100%; Deductible applies	**UR Notification required if admitted Inpatient.
Outpatient Surgical Facility	100%; Deductible applies	**UR Notification required or reduced benefit applies.
Routine Colonoscopy (includes polyp removal)	100%; Deductible waived	
Outpatient Therapy/Other Services Physical, Occupational and Manipulative Therapy Speech & Hearing Therapy Cardiac Rehabilitation Chemotherapy, Dialysis, Radiation Therapy	 100%; Deductible applies 100%; Deductible applies 100%; Deductible applies 100%; Deductible applies	 Limited to 40 visits combined per Calendar Year. Limited to 20 visits combined per Calendar Year. Contact UR Company for coordination of care.
Outpatient Diagnostic Services Select Diagnostic Medical Procedures Diagnostic Lab and X-ray Preventive and Wellness Lab and X-ray	 100%; Deductible applies 100%; Deductible applies 100%; Deductible waived	**UR Notification required or reduced benefit applies to Select Diagnostic Medical Procedures.

*****Based on Allowable Claim Limits
**Notification is required within forty-eight (48) hours following the services listed above (or the next business day if holiday or weekend admission) or reduced 80% benefit level applies.)

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LEVEL II PHYSICIAN BENEFITS – Payment Levels and Limits:
This section applies to Physicians and all other Providers of service not included as Facility Providers. Benefits shown are available **based upon the Provider's participation in the PPO network**.

Benefit Percentage For:	PPO Benefit*	Non-PPO Benefit **	Maximum Benefits, Limits & Provisions
Physician Hospital Visits/Surgeon	100% Deductible applies	80% Deductible applies	
Physician Hospital Visit for Mental & Nervous Disorders/Chemical Dependency, Drug and Substance Abuse	100% Deductible applies	80% Deductible applies	
Maternity (Including Prenatal delivery and Postnatal care)	100% Deductible applies	80% Deductible applies	Contact UR Company for coordination of care
Routine Newborn Care (Pediatric care to date of mother's discharge.)	100% Deductible waived	80% Deductible waived	Payable under covered mothers claim.
Office Visit (includes Exam, Treatment, Lab and X-ray (including Select Diagnostic Medical Procedures)	100% Deductible applies	80% Deductible applies	***UR Notification required or reduced benefit applies to Select Diagnostic Medical Procedures.
Allergy Testing, Serum and Injections	100% Deductible applies	80% Deductible applies	
Office Surgery	100% Deductible applies	80% Deductible applies	
Mental/Nervous Disorders and Substance Abuse Office Visits	100% Deductible applies	80% Deductible applies	
Urgent Care Facility Physician Medical Care (includes Lab and X-ray)	100% Deductible applies	80% Deductible applies	

* Based on PPO Negotiated rates
**Based on Usual and Customary fees
***Notification is required within forty-eight (48) hours following the services listed above (or the next business day if holiday or weekend admission) or reduced 80% benefit level applies.

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Benefit Percentage For:	PPO Benefit*	Non-PPO Benefit**	Maximum Benefits, Limits & Provisions
Select Diagnostic Medical Procedures/ Lab/X-ray (Freestanding facility or Independent Lab)	100% Deductible applies	80% Deductible applies	***UR Notification required or reduced benefit applies to Select Diagnostic Medical Procedures.
Home Health Services	100% Deductible applies	80% Deductible applies	Contact UR Company for coordination of care. Limited to 60 visits per Calendar Year.
Outpatient Therapies Physical, Occupational, Manipulative Therapy and Chiropractic	100% Deductible applies	80% Deductible applies	Limited to 40 visits combined per Calendar Year.
Speech and Hearing Therapy	100% Deductible applies	80% Deductible applies	Limited to 20 visits combined per Calendar Year
Chemotherapy, Dialysis, Radiation Therapy, Infusion Therapy	100% Deductible applies	80% Deductible applies	Contact UR Company for coordination of care.
Hospice (Inpatient Hospice and Home Hospice)	100% Deductible applies	80% Deductible applies	UR Notification required or reduced benefit applies for Inpatient. Contact UR Company for coordination of care Home Hospice.
Durable Medical Equipment and Medical Supplies	100% Deductible applies	80% Deductible applies	If over $500, requires prior authorization.
Prosthetic Devices and Orthotics	100% Deductible applies	80% Deductible applies	If over $500, requires prior authorization.
Ambulance Services (PPO DED/OOP applies to Non-PPO)	100% Deductible applies	100% Deductible applies	
All Other Provider Covered Physician Services	100% Deductible applies	80% Deductible applies	

* Based on PPO Negotiated rates

** Based on Usual and Customary fees

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Preventive and Wellness Care Benefits This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed Illness or Injury. Services must be identified and billed as routine or part of a routine physical exam/or as specified below.			
Benefit Percentage For:	**Level II PPO Benefit****	**Level II Non-PPO Benefit*****	**Limits & Provisions**
All Covered Wellness Benefits	100% Deductible waived	80% Deductible applies	See age and frequency limits and other special provisions below

Examples of Covered Wellness Procedures to include but are not limited to:

1. Routine Physical Exam
2. Annual Well Woman Exam
3. *Annual Pap smear and other routine lab
4. *Annual Routine Mammogram
5. *Bone Density test (routine)
6. Annual PSA test (routine)
7. Well Baby Care Exam/Well Child Care Exam
8. Vision Screenings (to age 19)
9. Hearing Screenings for newborns
10. Routine Immunizations
11. Flu vaccine/pneumonia vaccine
12. *Routine lab, x-ray, diagnostic testing and other medical screenings
13. Smoking/Tobacco Use Cessation (Limited to 1 Office Visit per Calendar Year)
14. *All FDA-approved Women's Contraceptive methods/Sterilization procedures
15. *Routine Colonoscopy (includes polyp removal and anesthesia)

*If these services are rendered by providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.
** Based on PPO Negotiated rates
** *Based on Usual and Customary fees

Prescription Drugs		
Prescription Drug Card - Retail (30 day supply) Generic Preferred Brand Non-Preferred Brand (Allows 90 day fill at a CVS pharmacy. Any other retail store, allows 2 30 day fills for maintenance medication, all others must be filled thru Mail Order.) **Mail Order** (102 day supply) Generic Preferred Brand Non-Preferred Brand **Specialty Drugs** Retail(30 Day Supply) Brand or Generic Copay	NETWORK PPO Deductible 100% PPO Deductible 100% PPO Deductible 100% PPO Deductible 100% PPO Deductible 100% PPO Deductible 100% PPO Deductible 100%	NON-NETWORK Non-PPO Deductible $5 Copay 50% Non-PPO Deductible $20 Copay 50% Non-PPO Deductible $40 Copay 50% Non-PPO Deductible $10 Copay 50% Non-PPO Deductible $40 Copay 50% Non-PPO Deductible $80 Copay 50% Non-PPO Deducible 50%

NOTE: This Summary of Benefits only represents an overview of your medical benefits and are subject to change. COMPLETE DETAILS OF YOUR MEDICAL PLAN WILL BE INCLUDED IN YOUR NEW/AMENDED ASSOCIATE BENEFIT BOOKLET.